

In Reply.—We appreciate Dr Drut's interest in our article entitled "Aspiration Cytology of Pediatric Solitary Papillary Hyperplastic Thyroid Nodule: Potential Pitfall."¹ We agree that hot thyroid nodules should not be aspirated since they rarely ever harbor malignancy. However, the 2 cases described in our series had a hot nodule with cold areas (case 1) and a warm nodule (case 2) on scan.¹ In case 1, fine-needle aspiration biopsy (FNAB) was performed to rule out the presence of papillary carcinoma in the cold areas. Although cold nodules are generally considered the most likely to be malignant, in some series, the highest relative frequency of cancer has been found in cases with normal (warm) nodules on scans.^{2,3} Hence, we believe that it is prudent for clinicians to perform FNABs in these cases, especially, since the incidence of malignancy in pediatric thyroid nodules may be as high as 33%.⁴ Thyroid function tests in these patients may reflect the hyperfunctioning state but cannot exclude malignancy, especially in a warm nodule or a hot nodule with cold areas. Indeed, a recent report describing the histologic features of functioning (therefore hot) nodules indicated that 8% were malignant.⁵ At our institutions, our clinicians do not perform FNABs on a hyperfunctioning hot thyroid nodule. Case 3 was obtained

from the consultation file of one of the authors (V.A.L.). We did not have clinical information on this patient. We included this case in our series since the diagnostic dilemmas in this case were similar to those in the other 2 cases described in our series. We would also like to clarify that the cytologic diagnosis of "suspicious for papillary carcinoma" in our 3 cases was not made solely on the basis of nuclear atypia or pleomorphism to which Dr Drut refers. The features that raised suspicion of papillary carcinoma were discussed in our paper and included cellular smears, transgressing vessels, papillary clusters, nuclear atypia and pleomorphism, presence of nuclear grooves, multinucleated giant cells, and cells with vacuolated cytoplasm.¹ To our knowledge, the cytologic presentation of pediatric solitary papillary hyperplastic thyroid nodule has not been previously described. In our experience, this lesion is a diagnostically challenging lesion on aspiration cytology. In our paper, we attempted to discuss the cytologic criteria that may be helpful in distinguishing solitary papillary hyperplastic thyroid nodule from papillary carcinoma. Increasing reliance on the diagnostic accuracy of thyroid fine-needle aspiration biopsy in selection of pediatric patients for surgery makes it imperative that a continuous effort is made to refine the cytologic criteria of lesions that may result in false-positive diagnosis and unnecessary surgical intervention.

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